STATE OF COLORADO

Employer Individual Notice for Family and Medical Leave

Agency Instruction: Complete for each specific event by an **eligible** employee that is, or potentially could be, on family/medical leave. This notice must be given within two (2) business days of the request for leave (one [1] week if a verbal designation), absent extenuating circumstances. A separate notice must be given for each individual qualifying condition.

DATE:

TO: SSN:

FROM:

Eligible employees may take up to 520 hours in a fiscal year (pro-rated for part time) if the event qualifies for family/medical leave. The following explains the rights and obligations under family/medical leave. It also explains the consequences if you fail to meet your obligations.

On _____ (date), I learned of your need to take leave beginning on _____ (date) due to:

- □ birth and care of your child or placement and care of a child for adoption/foster care;
- □ a serious health condition of your □ spouse, □ child, or □ parent. Documentation of familial relationship □ is or □ is not required; or,
- □ your own serious health condition.

1. **Designation.** You □ are not eligible until_____ (date), □ the requested leave does not qualify, □ you are eligible and the requested leave qualifies for family/medical leave and will be counted against your family/medical leave entitlement, □ you are eligible and the requested leave conditionally qualifies for family/medical leave pending further information, □ you are eligible and the requested leave qualifies but you have already used the hours allowed in this fiscal year.

   Optional: Family/Medical leave will expire on _____ (date).

2. **Medical Certification.** You □ are or □ are not required to furnish medical certification. If required, you must provide the certification, using the mandatory form, by _____ (date) (15 calendar days from the date of this notice). Failure to provide the certification by this date may result in the delay or denial of family/medical leave.

3. **Additional Medical Certificates.** You □ will or □ will not be required to furnish additional medical certificates relating to a serious health condition. The interval between certifications is every 30 calendar days or the period in the original certificate, if longer.

4. **Substitution of Paid Leave.** You are required to use your paid leave, except compensatory time, during family/medical leave before being placed on leave without pay. Paid leave includes accrued sick leave, as permitted by rule, and annual leave. Time from other leaves, e.g., short-term disability, holidays, funeral leave, leave-without-pay, etc., will be counted concurrently with the hours of family/medical leave you are entitled to during a fiscal year. If your absence is due to a compensable injury under workers compensation and you are being "made whole" using your accrued leave, the "make whole" period will not count toward your family/medical leave entitlement.

   Optional: Leave balance as of_____ (date) is _____ Sick and _____ Annual.

5. **Benefits.** □ During your ***paid*** leave, your insurance coverages will continue. Premiums will continue to be paid through normal payroll deduction.
   □ You have elected to continue insurance coverages during your ***unpaid*** leave. We will pay the State's portion of the premium and you must pay your portion of the premium by personal check or money order made payable to_____ for the amount of $_____(same amount deducted from your pay). Your payment is due to our payroll administrator/office by the **1st** of each month for the same month's coverage. If your payment for the month is not received within 30 days of the due date, your coverages may be canceled retroactive to the last month for which full payment was made. In the event any premium amount is due upon your return, you will be required to reimburse us once you have returned for at least 30 days. If you do not return to work following family/medical leave, reimbursement will still be required unless you have (1) the continuation, recurrence, or onset of a serious health condition, or (2) other circumstances beyond your control. **Contact our agency payroll administrator/office as soon as possible if you have any questions or to correct any errors. Be sure to mention family/medical leave.**

   □ You have elected **not** to continue insurance coverage during your ***unpaid*** leave, subject to Section 125 requirements. Any insurance claims during this time are your sole responsibility. Your coverages will be reinstated effective the date of your return to work on the same terms you had prior to taking family/medical leave, without any qualifying period, physical examination, pre-existing conditions, etc.

6. **Periodic Check In.** While on leave, you □ are not or □ are required to check in periodically, including information on your status, any change in circumstances, and intent to return to work so we can ensure that you receive all the benefits you are entitled to. Explain the mutually agreed upon schedule, including the interval(s) between check in:

7. **Fitness-To-Return Certificate.** You □ will or □ will not be required to present a fitness-to-return certificate prior to returning to work. I will supply the form. Failure to provide this certificate may delay your return until it is received. Failure to return to work may result in your termination upon exhaustion of leave.

8. **Restoration Rights.** (a) Upon return to work, you will be restored to your position or an equivalent one, i.e., same class title, pay, benefits, schedule, location, and other terms and conditions, subject to the provisions of the Family and Medical Leave Act of 1993.

   (b) While on ***unpaid*** leave, you will not be entitled to earn any type of paid leave and your anniversary date will be adjusted one month forward for every 173 hours of unpaid leave. While on ***paid*** leave, you will continue to earn leave and your anniversary date will remain unchanged. Leave will be credited and available for use when you return to work on a regular basis.

□ This notice has been discussed with me and I have received a copy. Knowingly providing false information directly, or through another party, may result in corrective or disciplinary action.

Employee Signature _____ Date _____

OR

□ Leave has begun and this notice was mailed (certified, return receipt requested) on_____ (date) to the employee's home address as listed in payroll records.

Authorized Signature _____ Date _____